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No. 97-53

In the Supreme Court of the United States

OCTOBER TERM, 1997

JANE M. ROBERTS, GUARDIAN FOR WANDA Y. JOHNSON, PETITIONER

v.

GALEN OF VIRGINIA, INC., FORMERLY DBA HUMANA HOSPITAL—UNIVERSITY OF LOUISVILLE, DBA LOUISVILLE HOSPITAL

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether a claim brought under the private cause of action provision of the Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd(d), requires proof of an improper motive as a prerequisite for recovery.

TABLE OF CONTENTS

	Page
Interest of the United States	1
Statement	2
Summary of argument	9
Argument:	
A violation of 42 U.S.C. 1395dd(b) occurs when a covered entity fails to stabilize a patient before transfer, regardless of the motive with which the entity acted	11
A. The text of EMTALA makes clear that establishing a violation does not require proof of motive	11
B. The legislative history of EMTALA supports the conclusion that a hospital's obligations under Section 1395dd(b) do not turn on the motive with which the hospital acts	18
C. The Secretary of Health and Human Services has taken the position that "improper motive" is not an element of an EMTALA violation	23
D. There is nothing in the "appropriate medical screening examination" provision of EMTALA, 42 U.S.C. 1395dd(a), that supports an improper motive requirement in Section 1395dd(b)	24
Conclusion	29

TABLE OF AUTHORITIES

Cases:

American Nat'l Red Cross v. *S.G.*, 505 U.S. 247 (1992)	18
Board of Educ. of the Hendrick Hudson Cent. Sch. Dist. v. *Rowley*, 458 U.S. 176 (1982)	25
Burditt v. *HHS*, 934 F.2d 1362 (5th Cir. 1991)	23

Cases—Continued: Page

Chevron U.S.A. Inc. v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) 23
Cleland v. *Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990) 6, 7, 10, 24
Correa v. *Hospital San Francisco*, 69 F.3d 1184 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996) 2, 26
Eberhardt v. *City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) 26
Gatewood v. *Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) 20, 25
Holcomb v. *Monahan*, 30 F.3d 116 (11th Cir. 1994) 26
Inter-Modal Rail Employees Ass'n v. *Atchison, T. & S.F. Ry.*, 117 S. Ct. 1513 (1997) 12
Martin v. *OSHRC*, 499 U.S. 144 (1991) 23
Oncale v. *Sundowner Offshore Servs., Inc.*, 118 S. Ct. 998 (1998) 19
Power v. *Arlington Hosp. Ass'n*, 42 F.3d 851 (4th Cir. 1994) 25
Repp v. *Anadarko Mun. Hosp.*, 43 F.3d 519 (10th Cir. 1994) 26
Summers v. *Baptist Med. Cent. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) 25
United States v. *Gonzales*, 117 S. Ct. 1032 (1997) 11
United States v. *Wiltberger*, 18 U.S. (5 Wheat.) 76 (1820) 11-12
Vargas v. *Del Puerto Hosp.*, 98 F.3d 1202 (9th Cir. 1996) 18
Vickers v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996) 26
Walters v. *Metropolitan Educ. Enters.*, 117 S. Ct. 660 (1997) 16

Statutes and regulations: Page

Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, Tit. IX, § 9121(b), 100 Stat. 164 19
Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd *et seq.* 1, 6, 8
42 U.S.C. 1395dd(a) 2, 8, 14, 24, 25, 27, 28, 29
42 U.S.C. 1395dd(b) ..... *passim*
42 U.S.C. 1395dd(b)(1)(A) 3, 9, 14
42 U.S.C. 1395dd(c) 3, 4, 5, 12
42 U.S.C. 1395dd(c)(1)(A)(ii) 16
42 U.S.C. 1395dd(c)(2) 4
42 U.S.C. 1395dd(d)(1) 1
42 U.S.C. 1395dd(d)(1) (1988) 16
42 U.S.C. 1395dd(d)(1)(A) 4
42 U.S.C. 1395dd(d)(1)(B) 4
42 U.S.C. 1395dd(d)(2) 1
42 U.S.C. 1395dd(d)(2) (1988) 17
42 U.S.C. 1395dd(d)(2)(A) 4, 18
42 U.S.C. 1395dd(d)(2)(B) 4, 18
42 U.S.C. 1395dd(d)(3) 17
42 U.S.C. 1395dd(e)(1)(A) 3, 9, 15
42 U.S.C. 1395dd(e)(1)(B) 3, 15
42 U.S.C. 1395dd(e)(2) 2
42 U.S.C. 1395dd(e)(3)(A) 3, 9, 13, 29
42 U.S.C. 1395dd(e)(3)(B) 3, 13
42 U.S.C. 1395dd(e)(4) 3
Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Tit. IV, § 4009(a), 101 Stat. 1330-56 22
101 Stat. 1330-57 22
Omnibus Budget Reconcilation Act of 1989, Pub. L. No. 101-239, Tit. VI, § 6211(a), 103 Stat. 2245 22
Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, Tit. IV, 104 Stat.:
Tit. IV, § 4008(b)(1), 104 Stat. 1388-44 17
§ 4008(b)(3)(A), 104 Stat. 1388-44 17
§ 4008(b)(3)(B), 104 Stat. 1388-44 17
§ 4027(a)(1)(A), 104 Stat. 1399-117 17
42 U.S.C. 1320a-7a 4
42 U.S.C. 1320c-5(a)(1) 18

Statutes and regulations—Continued:	Page
42 U.S.C. 1395f(c)	2
42 U.S.C. 1395y(a)(3)	2
42 U.S.C. 1395bb	14
42 U.S.C. 1395cc(a)(1)	17
42 U.S.C. 1395cc(a)(1)(I)	2, 17
42 U.S.C. 1395cc(b)(2)	2, 4, 17
42 U.S.C. 1395cc(b)(2)(A)	17
42 U.S.C. 1395qq	2
42 C.F.R. 489.24	2, 3, 14
42 C.F.R. 489.24(g)(2)(v)	17
Miscellaneous:	
131 Cong. Rec. (1985):	
p. 19,833	21
p. 28,568	22
p. 28,569	22
p. 29,829	21
p. 29,835	21
59 Fed. Reg. 32,086 (1994)	23, 27
H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. (1985)	21
H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. (1987)	22
H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. (1989)	22
H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1 (1985)	2, 19
H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3 (1985)	2, 19
The Random House Dictionary of the English Language (2d ed. 1987)	25
Department of Health and Human Services, *State Operations Manual Provider Certification* (1998)	27
Webster's Third New International Dictionary (1976)	25

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INTEREST OF THE UNITED STATES

This case concerns the requirements for establishing liability under the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd *et seq*. EMTALA requires hospitals with Medicare provider agreements, as a condition of eligibility, to provide all individuals who come to the hospital with essential emergency care. Similar requirements are imposed on physicians working at those hospitals. The United States plays an important role in the enforcement of EMTALA's requirements. Although private entities may bring an action under 42 U.S.C. 1395dd(d)(2) for damages and injunctive relief, the Secretary of Health and Human Services is responsible for enforcing the statutory requirements through civil

money penalties and through exclusion from participation in the Medicare and Medicaid programs. 42 U.S.C. 1395dd(d)(1); see also 42 U.S.C. 1395cc(b)(2); 42 C.F.R. 489.24. At the Court's invitation, the United States filed a brief as amicus curiae at the petition stage of this case.

STATEMENT

1. EMTALA was enacted in 1986 in an effort to ensure that individuals who needed emergency treatment were not turned away at the hospital door or transferred prematurely. H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 27 (1985); H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3, at 5 (1985). The Act, in 42 U.S.C. 1395dd(a) and (b), imposes two principal obligations on hospitals that have entered into Medicare provider agreements with the Secretary of Health and Human Services. 42 U.S.C. 1395dd(e)(2).[1]

First, when an individual comes to a covered hospital and a request is made on the individual's behalf for examination or treatment for a medical condition, the Act requires the hospital to provide "an appropriate medical screening examination within the capability of the hospital's emergency department * * * to determine whether or not an emergency medical condition * * * exists." 42 U.S.C. 1395dd(a). The Act does not define the term "appropriate medical screening examination." The term "emergency medical condition" is defined as a condition "manifesting itself by acute symptoms of sufficient severity * * * that the absence of immediate medical

[1] The statutory scheme governing the Medicare program requires participating hospitals to comply with the requirements of EMTALA. 42 U.S.C. 1395cc(a)(1)(I). Almost all non-federal hospitals have Medicare provider agreements. See *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1191 (1st Cir. 1995) ("ninety-nine percent of American hospitals [are] covered by EMTALA"), cert. denied, 517 U.S. 1136 (1996). With the exception of hospitals managed by the Indian Health Service, federally run hospitals are ineligible to enter into Medicare provider agreements. 42 U.S.C. 1395f(c); 1395qq; 1395y(a)(3).

attention could reasonably be expected to result in * * * serious jeopardy [to the health of the individual or her unborn child], * * * serious impairment to bodily functions, or * * * serious dysfunction of any bodily organ or part." 42 U.S.C. 1395dd(e)(1)(A). A separate definition of "emergency medical condition" covers a pregnant woman who is having contractions. 42 U.S.C. 1395dd(e)(1)(B). See generally 42 C.F.R. 489.24.

Second, if the hospital determines that an individual who has come to the hospital is suffering from an emergency medical condition, the hospital must either, "within the staff and facilities available at the hospital," provide "for such further medical examination and such treatment as may be required to stabilize the medical condition," or transfer the patient to another hospital in accordance with the provisions of subsection (c) of the Act. 42 U.S.C. 1395dd(b)(1)(A); see generally 42 C.F.R. 489.24.[2] The term "to stabilize" means "to provide such medical treatment of the [emergency medical] condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual." 42 U.S.C. 1395dd(e)(3)(A). The term "stabilized" is defined accordingly. 42 U.S.C. 1395dd(e)(3)(B).

Subsection (c) states that "[i]f an individual at a hospital has an emergency medical condition which has not been stabilized * * *, the hospital may not transfer the individual unless" the individual (or a legal representative) makes an informed, written request to be transferred; a physician has signed a certification that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or her unborn child; or, if a physician is not available, a qualified

[2] The Act defines "transfer" to include "discharge" of the individual. 42 U.S.C. 1395dd(e)(4).

medical person, in consultation with a physician, has made the required risk/benefit determination. 42 U.S.C. 1395dd(c). Subsection (c) further provides that in order for such a transfer to be appropriate, any receiving hospital must agree to accept the transfer of the individual and to provide appropriate medical treatment, and the sending hospital must forward all relevant medical records. 42 U.S.C. 1395dd(c)(2).

A participating hospital that negligently violates a requirement of the Act is subject to a civil money penalty of not more than $50,000 for each such violation. 42 U.S.C. 1395dd(d)(1)(A). Certain physicians who negligently violate a requirement of the Act with regard to an individual in a participating hospital are similarly subject to a civil money penalty of not more than $50,000 for each such violation. 42 U.S.C. 1395dd(d)(1)(B). If the violation is "gross and flagrant or is repeated," the physician is also subject to exclusion from participation in Medicare and federally funded state health care programs. *Ibid.* See also 42 U.S.C. 1395cc(b)(2): Civil money penalties and exclusions are imposed by the Secretary of Health and Human Services, pursuant to 42 U.S.C. 1320a-7a, as incorporated into 42 U.S.C. 1395dd(d)(1)(A) and (B).

The Act also provides for two private rights of action against participating hospitals, but not against physicians. The Act provides that "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of [EMTALA]" may bring a civil action to obtain those damages that are available for personal injury under the law of the State in which the hospital is located, as well as for appropriate equitable relief against the hospital. 42 U.S.C. 1395dd(d)(2)(A). The Act further provides that "[a]ny medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of [EMTALA]" may bring a civil action for similar damages and appropriate equitable relief. 42 U.S.C. 1395dd(d)(2)(B).

2. Wanda Y. Johnson was injured in May 1992 when she was struck by a vehicle while walking. Her injuries were life-threatening, and she was taken to the respondent hospital in Louisville, Kentucky, where she received treatment for the next two months. She suffered a series of infections and other complications, including pneumonia and urinary tract infections. Pet. App. A27.

In July 1992, respondent sought to transfer Johnson, who had no medical insurance, to a nursing home facility. At the time, she had symptoms of an active infection. She was placed on antibiotics and transferred on July 24, 1992, to Crestview Health Care Facility, a licensed nursing facility in Indiana, after two other nursing homes turned Johnson down following on-site evaluations of her condition by their directors of nursing. Pet. App. A2, A27. The day after she arrived at Crestview, Johnson's condition deteriorated and she was transported to Midwest Medical Center, an Indianapolis hospital. She remained at Midwest Medical Center for several months, incurring expenses in excess of $300,000. *Id.* at A27. The State of Indiana rejected Johnson's application for medical assistance under the Indiana Medicaid Program because Johnson failed to meet state residency requirements. *Id.* at A3.

3. On August 30, 1993, petitioner, as guardian for Johnson, filed suit in the United States District Court for the Western District of Kentucky, alleging, inter alia, that respondent had violated EMTALA by transferring Johnson to Crestview before the hospital had stabilized her condition. Petitioner, Johnson's aunt, did not allege that the initial screening that Johnson received was inappropriate, and respondent did not dispute that when Johnson arrived at the hospital she presented an emergency condition. Pet. App. A29. Nor did respondent claim to have complied with the provisions of 42 U.S.C. 1395dd(c) that permit the transfer of a patient whose emergency condition has not been stabilized. The case therefore

turned on whether Johnson had been properly stabilized under 42 U.S.C. 1395dd(b) before she was transferred.

The district court at first denied respondent's motion for summary judgment on the EMTALA claim. Pet. App. A45. The court concluded that there was a genuine issue of material fact as to whether Johnson was stabilized at the time of transfer. *Id.* at A36, A39. Citing the Sixth Circuit's decision in *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (1990), which the district court described as requiring "the presence of an improper motive as an essential element in a claim for relief under § 1395dd," the district court held that there was also a disputed issue of material fact as to whether the hospital acted with improper motive in transferring Johnson. Pet. App. A37.

The court based its ruling as to improper motive on evidence that a hospital social worker was facing considerable pressure to have Johnson discharged because the hospital was not being paid for her care. Pet. App. A37-A38.[3] Respondent moved for reconsideration, and in support of its motion, submitted affidavits from the physicians responsible for Johnson's discharge. The physicians all stated that Johnson was stable when transferred and that her financial condition did not influence their medical decision to authorize her transfer. *Id.* at A49-A50. The district court did not alter its previous conclusion that there was a material issue of fact regarding whether Johnson was stabilized at the time of transfer, but the court granted summary judgment to respondent because "the plaintiff presented no evidence that either the medical opinion that Johnson was stable or the decision to author-

[3] Joanna Nolte, a representative of Crestview Health Care Facility, testified that Nancy Fred, a social worker employed by respondent, explained to her that "they had been trying to discharge and with out any avail to other facilities and that she was getting a lot of pressure to discharge this person due to they knew they weren't going to get paid for this person." Pet. App. A14.

ize her transfer was caused by an improper motive[]." *Id.* at A50-A51.

4. The court of appeals affirmed the district court's judgment. Pet. App. A1-A25. The court of appeals stated that the district court "properly interpreted the *Cleland* holding as requiring that a plaintiff prove a hospital acted with an improper motive in order to recover under the EMTALA." *Id.* at A10. The court noted that *Cleland* defined the term "appropriate medical screening" not to refer to malpractice or some other standard of care, but rather to refer "to the motives with which the hospital acts." *Id.* at A8-A9 (quoting *Cleland*, 917 F.2d at 272). The court further noted that the *Cleland* court concluded that a showing of improper motive is not limited to a refusal to treat patients because of indigence but also includes "prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (*e.g.*, AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition." *Id.* at A9-A10 (quoting *Cleland*, 917 F.2d at 272).

The court of appeals reasoned that a plaintiff must prove improper motive in order to distinguish an EMTALA claim from a state law claim for malpractice. The court explained:

> We reject the position espoused by [petitioner] that, to succeed on a claim under the EMTALA, she can prove that [respondent's] treatment of Johnson was not uniform to patients suffering the same medical condition as Johnson. Proof of disparate treatment, in [petitioner's] view, distinguishes an EMTALA claim from a state law negligence claim. If we were to adopt this position, however, we would effectively require a hospital, in defense of a claim under EMTALA, to either prove that it breached a standard of care to an individual patient or that it breaches the applicable

> standard of care with respect to all similarly situated patients. In other words, we would require a hospital to prove that it has committed medical negligence or malpractice.

Pet. App. A11.

The court acknowledged that the issue in *Cleland* was whether the hospital had afforded the patient an "appropriate medical screening" in accordance with subsection (a) of 42 U.S.C. 1395dd, while the issue in the current case is whether the hospital failed to stabilize a patient with an emergency medical condition in violation of subsection (b) of that Section. Pet. App. A12 n.3. The court also noted that the term "appropriate medical screening," the linchpin of the court's analysis in *Cleland*, appears in subsection (a) but not in subsection (b). Nonetheless, explaining that it "s[aw] no rational reason to set forth differing standards when applying subsection[s] (a) and (b)," *ibid.*, the court of appeals concluded that *Cleland*'s improper motive requirement also applies in cases like this that arise under subsection (b).

As to the merits of the controversy before it, the court of appeals first noted that, under *Cleland*, physicians "are charged with the duty of stabilizing a patient's condition as it is known to them." Pet. App. A13. And the court further noted that respondent did not appeal the district court's holding that there was a genuine issue of material fact as to whether Johnson was stabilized when she was discharged by respondent. *Id.* at A14. The court nevertheless affirmed the district court's award of summary judgment for respondent, concluding that the district court correctly found that petitioner had failed to introduce evidence of improper motive that led to Johnson's discharge. *Id.* at A14-A16. Although the court acknowledged the evidence of the statement by the hospital social worker that she was facing pressure to discharge Johnson, the court emphasized that the social worker played no role in determining whether Johnson was in stable condition

before she was discharged, and that affidavits of the physicians who were involved stated that Johnson's financial status played no role in the discharge decision. See *ibid.*

Judge Nelson dissented in part. Pet. App. A23-A25. In his view, evidence that petitioner's treating physician relied on the hospital's social workers, together with evidence that the social workers were "receiving pressure from [respondent's] administration to get * * * Johnson discharged," *id.* at A25, was sufficient to raise "a genuine issue of fact as to whether [respondent] acted from an improper motive," *id.* at A24.

SUMMARY OF ARGUMENT

The text of EMTALA contains no suggestion that proof of improper motive is required to demonstrate that a hospital has failed, "within the staff and facilities available," to provide "such further medical examination and such treatment as may be required to stabilize the [patient's] medical condition." 42 U.S.C. 1395dd(b)(1)(A). That statutory language makes clear that the hospital's duty is to provide sufficient treatment "to stabilize the medical condition," without regard to the hospital's motive. Moreover, the statutory definition of "to stabilize" includes a requirement that the hospital assure "within reasonable medical probability" that the patient's condition is not likely to deteriorate during a transfer, and the definition of "emergency medical condition" refers to a condition that "could reasonably be expected to result in * * * serious jeopardy" to the patient's health. 42 U.S.C. 1395dd(e)(3)(A) and (e)(1)(A). Both of those "reasonableness" standards support the conclusion that EMTALA imposes an objective standard of care, and neither could be read to impose a further requirement that the hospital act with an improper subjective motive. Finally, EMTALA's sanctions provisions have from the beginning made clear that various sanctions may apply to a hospital that "negligently" violates the Act. Those provisions would be inexplicable if, as the Sixth Circuit held, violations of

EMTALA necessarily involve conduct that is more culpable than mere negligence because it was committed with an improper motive.

Although in enacting EMTALA Congress was concerned with "patient dumping"—refusing treatment to or transferring patients who could not pay for care—the legislative history confirms that Congress chose to address that problem through imposition of a substantive standard of medical care, not a prohibition against acting with an improper (non-medical) motive. Each of the relevant committee reports and statements in floor debates described the hospital's obligation under EMTALA in objective terms, and none suggested that proof of a violation depended on proof of improper motive. Finally, the Secretary of HHS has taken the position that improper motive is not an element of a violation of EMTALA. In light of the Secretary's enforcement responsibilities under EMTALA, that position is entitled to deference and, because it is reasonable, should be conclusive.

The Sixth Circuit attempted to justify its improper motive requirement on the ground that it had already held in *Cleland* v. *Bronson Health Care Group, Inc.*, 917 F.2d 266 (1990), that improper motive is an element of a violation of EMTALA's provision requiring hospitals to provide an "appropriate medical screening examination" to those who come to their emergency rooms. The "stabilization" provision at issue here, however, need not be construed to impose the same requirement as the "appropriate medical screening examination" provision, since neither the term the Sixth Circuit had found to be crucial in *Cleland*—"appropriate"—nor any similar term is present in the "stabilization" provision. Moreover, as both the Secretary and every other court of appeals to address the issue have concluded, the Sixth Circuit erred in holding that improper motive is an element even in an "appropriate medical screening examination" case. Every standard definition of the key word relied upon by the

Sixth Circuit—"appropriate"—makes clear that the word refers to the type of action, not the motive with which it is undertaken.

Finally, the policy concerns that drove the Sixth Circuit's decision are both doubtful and, in any event, insufficient to overcome the plain text, legislative history, and administrative interpretation of the Act. The Sixth Circuit stated that it was concerned that, if improper motive need not be shown, it would "effectively reduce the EMTALA to nothing more than a federal remedy for medical malpractice." Pet. App. A12. Insofar as that statement merely represents a disagreement with Congress's decision to embody a limited "reasonableness" standard in the stabilization provision, it is of little import. And in any event the adoption of an "improper motive" requirement would substitute for the legally familiar "reasonableness" standards in EMTALA an entirely indeterminate inquiry, unguided by the statutory text, regarding which motives are "improper." Because improper motive—however interpreted—is neither a necessary nor a sufficient element of a violation of EMTALA's stabilization requirement, the Sixth Circuit's decision should be reversed.

ARGUMENT

A VIOLATION OF 42 U.S.C. 1395dd(b) OCCURS WHEN A COVERED ENTITY FAILS TO STABILIZE A PATIENT BEFORE TRANSFER, REGARDLESS OF THE MOTIVE WITH WHICH THE ENTITY ACTED

A. The Text Of EMTALA Makes Clear That Establishing A Violation Does Not Require Proof Of Motive

The cardinal principle of statutory construction is that statutes should be construed in accordance with their plain language. "Where there is no ambiguity in the words, there is no room for construction." *United States* v. *Gonzales*, 117 S. Ct. 1032, 1036 (1997) (quoting *United States* v. *Wiltberger*, 18 U.S. (5 Wheat.) 76, 95-96 (1820)

(Marshall, C. J.)). Only an "absurd or glaringly unjust result" "would warrant departure from the plain language of" the statute. *Inter-Modal Rail Employees Ass'n* v. *Atchison, T. & S.F. Ry.*, 117 S. Ct. 1513, 1516 (1997) (citation and internal quotation marks omitted).

1. Section 1395dd(b) provides:

> If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
>
> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

In the circumstances of this case—which does not involve a transfer that purports to have satisfied subsection (c)—Section 1395dd(b) makes clear that a violation occurs if certain specified conditions are satisfied. First, an individual must have "come to a hospital." Second, the hospital must have determined that the individual has "an emergency medical condition." Third, the hospital must have failed to provide "for such further medical examination and such treatment as may be required to stabilize the medical condition." Fourth, such further examination and treatment must be "within the staff and facilities available at the hospital."

If all of the above conditions are satisfied, a hospital has violated the obligations imposed by the plain language of Section 1395dd(b). None of those conditions can reasonably be read to impose an additional condition that must be satisfied—that the hospital acted with any particular motive. A hospital may have a laudable motive to provide excellent care to its emergency room patients generally,

but it nonetheless may violate Section 1395dd(b) by failing to provide a "further medical examination" and "treatment" that would stabilize a particular patient's condition. Conversely, a hospital may generally intend to discriminate against patients who cannot pay—the immediate concern of the drafters of EMTALA, see pp. 18-19, *infra* — or against patients of another identifiable group, but nonetheless provide a "further medical examination" and "treatment" that stabilize one such patient prior to transfer. If so, the hospital may have violated some other provision of law, but it has not violated this provision of EMTALA. Although evidence of an improper motive may be probative as to various issues in an EMTALA case, the text of EMTALA contains no suggestion that proof of an improper motive is either necessary or sufficient to establish a violation of the "stabilization" requirements of Section 1395dd(b).

2. The definitions of the key terms in Section 1395dd(b) further specify the nature of a violation and the mental state of the party that commits a violation. They, too, make clear that an improper motive is not an element of a violation.

a. The most significant term in Section 1395dd(b) is "to stabilize," since a hospital's basic obligation under that provision is "to stabilize" a patient before transfer. The term "to stabilize" is defined to mean:

> to provide such medical treatment of [an emergency medical] condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to [a pregnant woman having contractions], to deliver.

42 U.S.C. 1395dd(e)(3)(A). The term "stabilized" is defined in a similar manner. 42 U.S.C. 1395dd(e)(3)(B).

Aside from the case of pregnant women having contractions—for whom special rules apply—the definition of "to stabilize" makes clear that a hospital's basic obligation is to see to it that the patient's emergency medical condition is not likely to deteriorate during, or as a result of, any transfer to another facility. The definition clarifies the mental state with which the hospital must act: it must assure "within reasonable medical probability" that the patient's condition will not likely deteriorate. The hospital is therefore not strictly liable for the patient's condition when it effects a transfer. If it acts "within reasonable medical probability" to assure that the patient's condition will likely suffer no material deterioration, the hospital has satisfied its obligations. Nothing in the definition of "to stabilize" suggests that a hospital that fails to assure "within reasonable medical probability" that a patient's condition will not likely deteriorate during or as a result of a transfer could nevertheless escape liability if the plaintiff fails to show that the hospital acted with some "improper" (presumably non-medical) motive.[4]

b. The statutory definition of the term "emergency medical condition" further supports the conclusion that a

[4] The standard of care under 42 U.S.C. 1395dd(b) is not one of ordinary "reasonableness" (*i.e.*, negligence); it instead requires merely that a hospital stabilize patients "within the staff and facilities available at the hospital." 42 U.S.C. 1395dd(b)(1)(A); accord 42 U.S.C. 1395dd(a) (requiring a hospital to provide an "appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department"). A hospital therefore cannot be held liable under Section 1395dd(b)(1)(A) on the ground that it "negligently" failed to have more specialized staff or facilities at the hospital. The Secretary has the authority under 42 U.S.C. 1395bb to promulgate regulations to further specify, consistent with the Act itself, the obligations of participating hospitals. See 42 C.F.R. 489.24 (responsibilities of participating hospitals in emergency cases).

violation may be established with no proof of an improper motive. That term is defined as

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in —
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part.

42 U.S.C. 1395dd(e)(1)(A).[5]

By once again incorporating a "reasonableness" standard—a failure to give medical attention that "could reasonably be expected" to result in jeopardy to health or impairment of bodily function—this definition reinforces the conclusion that hospitals need not guarantee that patients who come to emergency rooms will be correctly diagnosed and their emergency medical conditions successfully treated. But it also makes clear that hospitals must at least stabilize the conditions of those patients who could reasonably be expected to be placed in jeopardy without such treatment. Certainly the use of the familiar "reasonableness" standard cannot be read to suggest that the hospital will be liable only if it *intends* to treat a pa-

[5] A companion provision adds that a pregnant woman who is experiencing contractions has an emergency medical condition if "there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child." 42 U.S.C. 1395dd(e)(1)(B).

tient improperly or otherwise acts with an improper motive.[6]

3. As originally enacted, the sanctions under EMTALA included suspension or termination from the Medicare program, which could be imposed on a hospital that "knowingly and willfully, or negligently, fail[ed] to meet the requirements of [EMTALA]." 42 U.S.C. 1395dd(d)(1) (1988). If, as the Sixth Circuit held, violations of EMTALA require proof of improper motive, there could be no possibility of a "negligent" violation of the Act, and the use of the term "negligently" in the sanction provision would have been superfluous. See, *e.g.*, *Walters* v. *Metropolitan Educ. Enters.*, 117 S. Ct. 660, 664 (1997) ("Statutes must be interpreted, if possible, to give each word some operative effect."). Because, however, EMTALA from the beginning imposed requirements that did not turn on the presence of improper motive, the sanction provision's reference to negligence fits comfortably with the balance of the Act, permitting imposition of sanctions even when a hospital is at fault but cannot be shown to have acted with an improper motive.

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[6] EMTALA's provisions setting forth the alternative to the stabilization requirement also indicate that the statutory duty turns on objective factors, not the motive-based analysis adopted by the Sixth Circuit. Under those provisions, a hospital may transfer a patient whose condition has not been stabilized if a physician "has signed a certification that[,] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual * * * from effecting the transfer." 42 U.S.C. 1395dd(c)(1)(A)(ii). The statutory duty thus is based upon an analysis of what is "reasonably expected"—not the motive with which the hospital or physician made the transfer. Similarly, Section 1395dd(d)(1)(B)(i) imposes liability on a physician who signed such a certificate "if the physician knew or should have known that the benefits did not outweigh the risks." The "should have known" standard suggests that the physician's duty is not merely to refrain from acting with an improper motive.

In amendments added by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Pub. L. No. 101-508, Tit. IV, § 4008(b)(3)(A) and (B), 104 Stat. 1388-44, the EMTALA provision regarding termination or exclusion from Medicare was repealed, and it was replaced by the incorporation of more general provisions permitting the Secretary of Health and Human Services to terminate from the Medicare program a participating hospital that fails to fulfill its obligation to comply substantially with the provisions of its provider agreement, including the commitment to comply with EMTALA. See 42 U.S.C. 1395cc(a)(1) and (a)(1)(I), 1395cc(b)(2) and (b)(2)(A). At the same time, however, Congress amended the EMTALA civil penalty provisions. Under EMTALA as originally enacted, the Secretary could impose civil monetary penalties on hospitals and physicians who "knowingly violate[d] a requirement of [EMTALA]." 42 U.S.C. 1395dd(d)(2) (1988). In OBRA 1990, Congress substituted the term "negligently" for the term "knowingly" in that provision. Tit. IV, § 4008(b)(1), 104 Stat. 1388-44. That change would be inexplicable if EMTALA could only be violated by a hospital that acted with an improper motive.[7] See

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[7] In OBRA 1990, Congress also provided for the first time that, "[i]n considering allegations of violations of [EMTALA] in imposing [civil penalties]," the Secretary shall "request the appropriate utilization and quality control peer review organization [PRO] * * * to assess whether the individual involved had an emergency medical condition which had not been stabilized." OBRA 1990, § 4027(a)(1)(A), 104 Stat. 1399-117, codified at 42 U.S.C. 1395dd(d)(3). The role of the PRO is to address quality of care issues — not motivation. See 42 C.F.R. 489.24(g)(2)(v) (PRO should provide an "expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual's emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there were any medical utilization or quality of care issues involved in the case."). Congress's decision to require use of the PRO mechanism in civil penalty actions under EMTALA further supports the conclusion that Congress understood that EMTALA liability is

American Nat'l Red Cross v. *S.G.*, 505 U.S. 247, 263 (1992) ("canon[s] of statutory construction requir[e] a change in language to be read, if possible, to have some effect") (internal citations omitted). But the change is entirely explicable if the Act can be violated by hospitals that negligently fail to stabilize a patient before transfer. In that event, the amendment expressed Congress's reasonable decision in 1990 that the enforcement mechanism of civil penalties would be useful to deter such negligent violations.[8]

B. The Legislative History Of EMTALA Supports The Conclusion That A Hospital's Obligations Under Section 1395dd(b) Do Not Turn On The Motive With Which The Hospital Acts

1. EMTALA was originally enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985

based on adherence to a medical standard of care, not subjective motivation. Indeed, Medicare providers generally have an obligation to provide services of "a quality which meets professionally recognized standards of care." 42 U.S.C. 1320c-5(a)(1).

[8] Since its enactment, EMTALA's private right of action provision has specified only that an individual or a medical facility suffering "personal harm" or "a financial loss" as a direct result of a violation may bring a private suit for damages or equitable relief. 42 U.S.C. 1395dd(d)(2)(A) and (B). Although that provision does not itself specify "negligence" or any other standard to govern such an action, we believe that the EMTALA provisions cited above that define a hospital's obligations in terms of reasonableness make clear that a private suit based on an asserted violation of Section 1395dd(b) must rest at least on an allegation of negligence with respect to the duties imposed by those provisions. Whether there are obligations imposed by other provisions of EMTALA that would support a private suit not resting on a negligence standard is not at issue in this case and has not been extensively litigated in the lower courts. Cf. *Vargas* v. *Del Puerto Hosp.*, 98 F.3d 1202, 1206 (9th Cir. 1996) (holding hospital not liable "for what amounts to a clerical deficiency in record-keeping where the evidence indicates that the transfer was effected for medical reasons").

(COBRA 1985), Pub. L. No. 99-272, Tit. IX, § 9121(b), 100 Stat. 164. It arose from "a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured." H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3, at 5 (1985). See also H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 27 (1985) (Congress was "greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance."). In some cases, "treatment was simply not provided," while in others "patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital." *Ibid.* That practice was known as "patient dumping."

2. Although Congress's principal concern in enacting EMTALA was the problem of patient dumping, Congress had available a number of possible means to address that problem. "[S]tatutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed." *Oncale* v. *Sundowner Offshore Servs., Inc.*, 118 S. Ct. 998, 1002 (1998). Thus, the fact that Congress was concerned with patient dumping does not establish just how it chose to address that problem or what substantive obligations it chose to impose on hospitals to ensure that proper care is provided.

Congress surely could have enacted a statute prohibiting intentional discrimination against certain classes of patients. Had it done so, however, it is reasonable to expect that the statute would include some language embodying the discrimination standard or otherwise indicating that such a standard was intended. EMTALA contains no such language. Because differences in treatment (for example, among patients suffering different medical conditions) cannot all be prohibited, it would also

be expected that Congress would specify precisely which types of intentional discrimination—*i.e.*, which motives—were prohibited. Yet EMTALA contains no specification of which types of discrimination would be prohibited, and it otherwise offers a court no help in determining which "motives" might be considered "improper," and thus the basis for a violation.[9] The logical conclusion to be drawn from the absence of any such specification is that Congress chose not to take the approach of forbidding discrimination based on improper subjective motives when it enacted EMTALA.

3. Instead of addressing the problem of patient dumping through a motive-based prohibition, Congress chose to require hospitals to satisfy a substantive standard of care. It would obviously have been difficult or impossible to specify the precise minimum procedures that hospitals must use to treat each of the myriad emergency medical conditions they face in emergency rooms. Accordingly, Congress chose instead to impose a general "reasonableness" standard, not unfamiliar in other areas of law, but

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[9] The Sixth Circuit itself has stated that improper motives include the patient's "indigency or lack of insurance[,] * * * race, sex, politics, occupation, education, personal prejudice, drunkenness, or spite," Pet. App. A11, and "prejudice against the * * * ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition," *id.* at A9-A10. The Sixth Circuit did not explain how it determined that these were improper motives or whether other motives—such as a desire to limit treatment based on local residency or medical condition—would also be "improper" under EMTALA. Moreover, limiting EMTALA's coverage to individuals whose personal characteristics might trigger substandard care on one of the grounds identified by the Sixth Circuit would be inconsistent with EMTALA's statements that its duties are owed by hospitals to "any individual" who seeks medical treatment or is found to have an emergency condition. See *Gatewood* v. *Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991).

with modifications—such as the need for a hospital only to act within its available personnel and facilities, see note 4, *supra* — to suit the present context.

The Conference Report on EMTALA made clear that it was adopting the House proposal that "all participating hospitals must * * * provide further examination and treatment within their competence to stabilize the medical condition or provide treatment for the labor." H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 473 (1985). That is not a motive-based standard. Moreover, although the House bill required provision of "medical treatment * * * to assure that no material deterioration of the [emergency medical] condition is likely to result from the transfer of the individual," the Senate bill added that the treatment must only provide such assurance "within reasonable medical probability." *Id.* at 477. The Conference Committee adopted the House provision, but modified it with the Senate's "within reasonable medical probability" standard. *Id.* at 478. That compromise demonstrates that Congress focused on the precise standard of care to be embodied in EMTALA, and concluded that, while an absolute guarantee of medical results would be too exacting, a "medical reasonableness" standard would provide sufficient protection against patient dumping.

The Senate floor debates on the bill similarly leave no doubt that Congress chose to address the problem of emergency treatment and stabilization by imposing a medical standard of care—not merely a prohibition against intentional discrimination—on participating hospitals.[10] Senator Durenberger, the bill's floor manager, stated that the bill would "make it clear that the Medicare Program will not do business with any institution which willfully and knowingly, *or through negligence*, turns its back on an

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[10] The debate on COBRA on the House floor rarely touched on EMTALA, and it does not clarify the instant question. See 131 Cong. Rec. 29,829 (1985) (Rep. Stark), 19,833 (Rep. Bilirakis), 29,835 (Rep. Madigan).

emergency medical situation." 131 Cong. Rec. 28,568 (1985) (emphasis added). Senator Kennedy, a co-sponsor, similarly stated that "every patient who has a bonafide emergency must receive stabilizing care." *Id.* at 28,569. Senator Dole, another co-sponsor, referred to the problem of patient dumping, and added that "a hospital is charged only with the responsibility of providing an adequate first response to a medical crisis," which "means that a patient must be evaluated and, at a minimum, provided with whatever medical support services and/or transfer arrangements that are consistent with the capability of the institution and the well-being of the patient." *Ibid.* Those statements evidence Congress's intent to address the problem of patient dumping by imposing a medical standard of care, not a prohibition against intentional discrimination.

4. EMTALA has been amended on several occasions since 1986. Aside from the amendment to the civil penalty provision in 1990 (see pp. 17-18, *supra*), most of those amendments did not address the nature of the duty imposed by EMTALA on participating hospitals. But on each occasion, the discussions in the committee reports concerning EMTALA's requirements referred only to the hospital's duty to provide sufficient care to stabilize the patient's condition.[11] They nowhere suggested that improper motive is an element of a statutory violation.

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[11] See, *e.g.*, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Tit. IV, § 4009(a), 101 Stat. 1330-56 to 1330-57, discussed in H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. 540, 543, 547 (1987) (describing EMTALA as requiring a hospital to "provide, within its capabilities, examination and treatment to stabilize the medical condition or to administer [*sic*] to the labor," and leaving that standard unchanged); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, Tit. VI, § 6211(a), 103 Stat. 2245, discussed in H.R. Conf. Rep. No. 386, 101st Cong., 1st Sess. 835, 837, 839 (1989) (describing EMTALA as requiring hospitals to "provide medical services necessary to stabilize the individual or to provide for treatment of the labor," and leaving that standard unchanged).

C. The Secretary Of Health And Human Services Also Has Taken The Position That "Improper Motive" Is Not An Element Of An EMTALA Violation

As noted previously, p. 4, *supra*, the Secretary of Health and Human Services administers the civil monetary fine provisions of EMTALA, and she may also exclude physicians who violate EMTALA from eligibility for Medicare or Medicaid reimbursements. Similarly, the Secretary may terminate a hospital's eligibility for federal reimbursements if the hospital violates EMTALA. Because the Secretary has an important role in the administration of EMTALA, her interpretation of EMTALA is entitled to deference. See *Martin* v. *OSHRC*, 499 U.S. 144 (1991); *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-845 (1984).

The Secretary has concluded that proof of an improper motive is not an essential element of a violation of Section 1395dd(b). In the preamble to Interim Final Rules and Regulations that remain in effect and that govern the Department's Health Care Financing Administration and its Office of Inspector General, the Secretary stated that "with regard to appropriate transfers, * * * the Secretary has taken the position that in proving that a hospital or physician has violated [42 U.S.C. 1395dd(b)], there is no requirement to prove that the transfer was effected due to some 'impermissible motive.'" 59 Fed. Reg. 32,086, 32,104 (1994). As the Secretary explained, that position was not a new one, since it had already been upheld by the Fifth Circuit three years earlier in *Burditt* v. *HHS*, 934 F.2d 1362 (5th Cir. 1991). Thus, even if the text and legislative history of 42 U.S.C. 1395dd(b) were ambiguous, the Secretary's reasonable interpretation that

proof of a violation does not require proof of an improper motive would settle the matter.

D. There Is Nothing In The "Appropriate Medical Screening Examination" Provision Of EMTALA, 42 U.S.C. 1395dd(a), That Supports An Improper Motive Requirement In Section 1395dd(b)

Rather than purporting to find any language in Section 1395dd(b) that could be construed to impose an improper motive requirement, the Sixth Circuit relied heavily on its prior decision in *Cleland*, which arose under Section 1395dd(a)'s "appropriate medical screening" provision. *Cleland* held that " 'appropriate' must * * * be interpreted to refer to the motives with which the hospital acts." 917 F.2d at 272. The court in this case applied that holding to Section 1395dd(b) because it "s[aw] no rational reason to set forth differing standards when applying subsection[s] (a) and (b)." Pet. App. A12 n.3. Accordingly, the Sixth Circuit's conclusion with respect to subsection (b) of Section 1395dd that "a plaintiff [must] prove a hospital acted with an improper motive in order to recover under the EMTALA," *id.* at A10, rests, at bottom, on its construction in *Cleland* of the term "appropriate medical screening" in subsection (a).

1. The Sixth Circuit erred in concluding that there is no "rational reason" to impose differing liability standards under the "appropriate medical screening examination" (subsection (a)) and "stabilization" (subsection (b)) provisions of EMTALA. Even if the Sixth Circuit were correct that the term "appropriate" in subsection (a) could be construed as imposing an improper motive requirement, neither the term "appropriate" nor any similar term appears in subsection (b). Because no other term in subsection (b) can plausibly be read to impose an improper motive requirement, the difference in statutory language would be a more than sufficient basis for concluding that, regardless of the obligations imposed by subsection (a),

liability under subsection (b) does not turn on proof of an improper motive.

2. More fundamentally, the Sixth Circuit erred in apparently construing an "appropriate medical screening examination" under subsection (a) to include an examination that is medically inefficacious and unreasonable but that is conducted with a "proper" motive. The word "appropriate" is susceptible to a wide range of meanings, but construing it to mean "without improper motivation" is to confer on the word a meaning not found in any standard dictionary and not known to common usage.[12] Respondent cites no case, and we are aware of none, in which a court has construed the word "appropriate" as used in any other statute to mean "without improper motivation."[13]

All three other courts of appeals to address the issue have rejected the Sixth Circuit's holding that proof of a violation of the subsection (a) "appropriate medical screening examination" requirement requires proof of an improper motive.[14] In addition, four other courts of appeals have discussed the scope of EMTALA liability under subsection (a) with no mention of an improper motive re-

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[12] See, *e.g.*, *The Random House Dictionary of the English Language* 103 (2d ed. 1987) (defining "appropriate" as "suitable or fitting for a particular purpose, person, occasion"); *Webster's Third New International Dictionary* 106 (1976) ("specially suitable: fit, proper").

[13] Cf. *Board of Educ. of the Hendrick Hudson Cent. Sch. Dist.* v. *Rowley*, 458 U.S. 176, 188-189 (1982) (construing "free appropriate public education" for a handicapped child to mean "educational instruction specially designed to meet the unique needs of the handicapped child, supported by such services as are necessary to permit the child 'to benefit' from the instruction").

[14] See *Gatewood* v. *Washington Health Care Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991); *Power* v. *Arlington Hosp. Ass'n.*, 42 F.3d 851, 857 (4th Cir. 1994); *Summers* v. *Baptist Med. Cent. Arkadelphia*, 91 F.3d 1132, 1137-1138 (8th Cir. 1996) (en banc).

quirement.[15] Each of those courts has construed the term "appropriate" in 42 U.S.C. 1395dd(a) to refer to the type of screening provided to an emergency room patient, not to the motivation underlying a medical screening that fails to satisfy a standard of medical suitability.

Aside from rejecting the Sixth Circuit's improper motive requirement, the courts of appeals have differed regarding whether the "appropriate medical screening examination" requirement imposes merely an obligation that each participating hospital screen all patients for the existence of an emergency medical condition equally, or whether it also imposes a substantive minimum standard of care. Compare, *e.g.*, *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995) (screening must be "reasonably calculated to identify critical medical conditions") and *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995) ("The touchstone is whether * * * the [screening] procedure is designed to identify an 'emergency medical condition,' that is manifested by 'acute' and 'severe' symptoms.") with *Summers* v. *Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996) ("An inappropriate screening examination is one that has a disparate impact on the plaintiff.") and *Holcomb* v. *Monahan*, 30 F.3d 116, 117 (11th Cir. 1994) ("As long as a hospital applies the same screening procedures to indigent patients [as] it applies to paying patients, the hospital does not violate [Section 1395dd(a).").

To some extent, the differences among the circuits on this point may be more apparent than real. Hospitals can be expected generally to provide medically reasonable care to their patients, both because professional medical

[15] See *Correa* v. *Hospital San Francisco*, 69 F.3d 1184, 1192 (1st Cir. 1995), cert. denied, 517 U.S. 1136 (1996); *Eberhardt* v. *City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995); *Repp* v. *Anadarko Mun. Hosp.*, 43 F.3d 519, 522 (10th Cir. 1994); *Holcomb* v. *Monahan*, 30 F.3d 116, 117 (11th Cir. 1994); see also *Vickers* v. *Nash Gen. Hosp., Inc.*, 78 F.3d 139, 143 (4th Cir. 1996).

standards require such care and because of the threat of tort liability under state law. Thus, a hospital that provides the same procedures for determining the existence of an emergency medical condition to indigent patients as to paying patients may ordinarily be expected to be found to have given medically reasonable care to all. The Secretary of Health and Human Services has stated, however, that the "appropriate medical screening examination" provision of EMTALA requires screening examinations that are both equal in the relevant respects to those provided to other patients and, at a minimum, adequate to determine whether an individual is suffering from an emergency medical condition.[16] As noted above, her view

[16] In the preamble to the Interim Final Rules and Regulations cited previously (see p. 23, *supra*), the Secretary declined to define the term "appropriate medical screening examination" because of the wide range of medical conditions presented to emergency rooms and the wide range of capabilities in facilities and personnel available to hospitals. But she stated that, "[w]ithin those capabilities, the examination must be sufficient to permit the hospital to decide whether or not the individual has an emergency medical condition." 59 Fed. Reg. 32,086, 32,099 (1994); see also Department of Health and Human Services, Health Care Financing Administration, *State Operations Manual: Provider Certification*, at V-19 (1998). Discussing whether hospitals could maintain procedures requiring emergency room personnel to ask emergency room patients whether they had insurance without violating EMTALA, she stated that such a practice was acceptable "as long as all individuals to whom the procedures apply are treated similarly. That is, all individuals who have an emergency medical condition are served regardless of the answers they may give to insurance questions during routine admission screening." 59 Fed. Reg. at 32,099. See also *id.* at 32,100 ("The thrust of the statute is that a hospital that offers emergency services to some members of a community who need their emergency services (for example, those that can pay) cannot deny such services to other members of the community with a similar need."); *State Operations Manual: Provider Certification*, *supra*, at V-19 ("The medical screening examination must be the same medical screening examination that the

is entitled to deference. But whatever may be the correct interpretation of the "appropriate medical screening examination" requirement in subsection (a) of EMTALA, the Sixth Circuit's rule that improper motive be shown under that provision is at odds with the views of each of the other circuits that has considered the issue and with the views of the Secretary, which should be controlling on this point.

3. The Sixth Circuit stated that one reason for requiring improper motive to be shown in an action under both subsection (a) and subsection (b) was that dispensing with proof of improper motive and resting a claim under EMTALA solely on a lack of uniform treatment would "effectively require a hospital, in defense of a claim under EMTALA, to either prove that it breached a standard of care to an individual patient or that it breaches the applicable standard of care with respect to all similarly situated patients." Pet. App. A11. Presumably, the court was referring to a case in which the plaintiff proves that the hospital breached a medical standard of care. In such a case, the court believed that the hospital would be placed in the "precarious position" of having to prove that it committed the same breach with respect to all of its patients. *Ibid.*

The Sixth Circuit's policy concerns are not sufficient to overcome the plain language, history, and authoritative administrative construction of subsection (b) of EMTALA. Those policy concerns also rest on a false dilemma. If EMTALA merely required uniform treatment of patients with similar medical conditions, the issue of negligence would be irrelevant. If the plaintiff nonetheless argued that the hospital's care was substandard, the hospital could be expected to respond that the treatment it provided to the plaintiff and to all of its patients is satisfactory; the hospital surely would not have to admit (or prove) that it

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hospital would perform on any individual coming to the hospital's emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care.").

was negligent with respect to anyone. More fundamentally, as we have explained above (see pp. 12-16, *supra*), EMTALA imposes minimum substantive standards of medical care under both subsections (a) and (b). Thus, a hospital would defend against an EMTALA subsection (b) suit by proving that, within the available staff and facilities, the hospital had stabilized the condition of the patient "within reasonable medical probability." 42 U.S.C. 1395dd(e)(3)(A). Because that is akin to the kind of negligence standard that is familiar in state tort law, it puts hospitals in no more "precarious position" than does state tort law. Indeed, it is far easier to use well-developed standards of medical reasonableness to assess conduct in an EMTALA suit than it would be to determine—with no help from the statutory language—just which motives for differential treatment were "improper" under the Sixth Circuit's open-ended test.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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